RCT on the Management of Early Pregnancy Failure
SCHEDULED STUDY VISIT

Site			Patient No.			Letter Code		Visit	

A. DIAGNOSIS AND FURTHER TREATMENT

1. Visit Date: ___ ___ ___ - ___ ___ - 2 0 0 ___ FM08DT
   Month Day Year

Complete Form 03 – Physical Examination, Laboratory Assessment and Transvaginal Ultrasound Form at All Visits.

2. Has the patient experienced a serious adverse event: (1) Yes (2) No ADVEVNT

IF YES, COMPLETE FORM 09 – SERIOUS ADVERSE EVENT FORM.

3. Based on all the evidence available, is the expulsion of products of conception complete?
   Complete (1)
   Incomplete (2) EXPLCMPL

4. Further treatment:
   None (1)
   Misoprostol (2)
   D&C (3) ADDTRMT

IF NONE, SKIP TO SECTION B.

IF MISOPROSTOL, COMPLETE FORM 05.
IF D&C, COMPLETE FORM 06.

5. Reason(s) for the recommended treatment:

		Yes	No	
A.	Per protocol	(1)	(2)	TRTPROT
B.	Per patient request, chief complaint	(1)	(2)	TRTPAT
	If Yes, Specify _____			TRTPATSP
C.	Clinically indicated	(1)	(2)	TRTCLN
	If Yes, Specify _____			TRTCLNSP
D.	Other	(1)	(2)	TRTOTH
	If Yes, Specify _____			TRTOTHSP

B. ADMINISTRATIVE MATTERS

1. Comments: _____ GEN_CMNT

2. Person completing form: _____ CERT_SIG Staff Number: __ __ __ - __ __ __ CERT_NO

3. Date form completed: ___ ___ ___ - ___ ___ - 2 0 0 ___ COMPL_DT
   Month Day Year